Sample Forms

Sample Forms:
List & Description

The Section for Communicable Disease Prevention uses the following forms:

CD-1 Disease Case Report: Used by any health care provider or laboratory to report reportable disease (**including tuberculosis infection and disease,** but not AIDS/HIV) according to RSMo 192.006 and 192.020; 19 CSR 20-20.020 and 19 CSR 20-080 (See Appendix 3).

TBC-1 Tuberculosis Drug Monitoring: Used to document monthly monitoring of persons on antituberculosis medications for **tuberculosis disease.** (For persons taking preventive treatment for tuberculosis infection, see TBC-4.)

TBC-2 Form to Document Refusal of Isoniazid Infection Treatment of Tuberculosis: Used to inform the person of the benefits of taking preventive treatment for tuberculosis infection, and to obtain their signature that they are refusing preventive treatment. May encourage the person to think carefully about the consequences of refusal.

TBC-4 Tuberculin Testing Record (revised 1996): Used by local health departments to document and report to the Section for Communicable Disease Prevention, Disease Investigation Unit are the following:

Patient demographics and locating information
History of past tuberculin tests and BCG vaccination
Reason for testing
Risk factors
Consent for testing and contract to return for reading
Current tuberculin skin test result
Follow-up chest x-ray
Treatment recommendations
Baseline assessment data for preventive treatment
Monthly monitoring of preventive treatment
Completion of preventive treatment
This form can also be used as a Preventive Treatment register and tickler file. (According RSMo 192.006 and 192.020; 19 CSR 20-20.020 and 19 CSR 20-080; local statutes and ordinances).

TBC-10 Tuberculosis History: Used to determine current status and previous history of persons with tuberculosis disease ONLY.

TBC-13 Tuberculosis Worksheet for Contacts of Newly Diagnosed Cases of Tuberculosis: Used to document the results of tuberculin skin tests of all Identified contacts to tuberculosis disease. The form is to be completed by three months after the case is initially identified. A copy of the form is forwarded to the Section for Communicable Disease Prevention, Disease Investigation Unit through the district tuberculosis control nurse.

TBC-15A Tuberculosis Case Register Card: Used by the Section for Communicable Disease Prevention, Disease Investigation Unit Registrar to maintain current information on all tuberculosis disease patients in the Out state (non-metropolitan) areas. May be used by any LPHA as an aid to maintaining current information on their patients with tuberculosis disease in one central Location (i.e. a register).

TBC-18 Tuberculin Skin Test Record: Used by any health care provider to furnish a record for proof of tuberculin skin test results to persons who need such proof for employment or other purposes. There is space for up to seven (7) results, with type of test, dates given and read, agency, and provider signature.

OTHER SAMPLE FORMS

Annual Statement for Tuberculin Reactors
Checklist for Active Disease
Diagnostic Services Eligibility/Authorization
Medication Request Form
Nursing Care Plan
Signs/Symptoms Checklist (English)
Sings/Symptoms Checklist (Spanish)

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

DISEASE CASE REPORT

REPORT TO LOCAL PUBLIC HEALTH AGENCY

1 DATE OF REPORT	**2** DATE RECEIVED BY LOCAL HEALTH AGENCY
_____ / _____ / _____	_____ / _____ / _____

3 NAME (LAST, FIRST, M.I.)	**4** GENDER ☐ MALE ☐ FEMALE	**5** DATE OF BIRTH _____ / _____ / _____	**6** AGE	**7** HISPANIC ☐ YES ☐ NO ☐ UNKNOWN

8 RACE (CHECK ALL THAT APPLY) ☐ BLACK ☐ ASIAN ☐ PACIFIC ISLANDER ☐ WHITE ☐ AMERICAN INDIAN ☐ UNKNOWN	**9** PATIENT'S COUNTRY OF ORIGIN	**10** DATE ARRIVED IN USA _____ / _____ / _____

11 ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)	**12** COUNTY OF RESIDENCE	**13** TELEPHONE NUMBER ( )

14 PREGNANT ☐ YES (IF YES NUMBER OF WEEKS _____) ☐ NO ☐ UNKNOWN	**15** PARENT OR GUARDIAN	**16** RECENT TRAVEL OUTSIDE OF MISSOURI OR USA ☐ YES ☐ NO IF YES, WHERE _____	**17** DATE OF RETURN _____ / _____ / _____

18 OCCUPATION	**19** SCHOOL/DAY CARE/WORKPLACE ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)

20 WORK TELEPHONE NUMBER ( )	**21** OTHER ASSOCIATED CASES ☐ YES ☐ NO ☐ UNKNOWN IS REPORT PART OF AN OUTBREAK ☐ YES ☐ NO ☐ UNKNOWN	**22** TYPE OF COMPLAINT/OUTBREAK ☐ FOODBORNE ☐ WATERBORNE ☐ OTHER (SPECIFY) _____

23 WAS PATIENT HOSPITALIZED ☐ YES ☐ NO ☐ UNKNOWN	**24** PATIENT RESIDE IN NURSING HOME ☐ YES ☐ NO ☐ UNKNOWN	**25** PATIENT DIED OF THIS ILLNESS ☐ YES ☐ NO ☐ UNKNOWN

26 CHECK BELOW IF PATIENT OR MEMBER OF PATIENT'S HOUSEHOLD (HHLD):	PATIENT			HHLD MEMBER		
	YES	NO	UNK	YES	NO	UNK
IS A FOOD HANDLER						
ATTENDS OR WORKS AT A CHILD OR ADULT DAY CARE CENTER						
IS A HEALTH CARE WORKER						

27 NAME OF HOSPITAL/NURSING HOME	
28 HOSPITAL/NURSING HOME ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)	
29 REPORTER NAME	**30** TELEPHONE NUMBER ( )

31 REPORTER ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)	**32** TYPE OF REPORTER/SUBMITTER ☐ PHYSICIAN ☐ OUTPATIENT CLINIC ☐ PUBLIC HEALTH CLINIC ☐ HOSPITAL ☐ LABORATORY ☐ SCHOOL ☐ OTHER _____

33 ATTENDING PHYSICIAN/CLINIC NAME ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)	**34** TELEPHONE NUMBER ( )

35 DISEASE NAME(S)	**36** ONSET DATE(S) _____ / _____ / _____ _____ / _____ / _____	**37** DIAGNOSIS DATE(S) _____ / _____ / _____ _____ / _____ / _____	**38** DISEASE STAGE/ RISK FACTOR	**39** PREVIOUS DISEASE/STAGE	**40** PREVIOUS DISEASE DATE(S) _____ / _____ / _____ _____ / _____ / _____

41 - DIAGNOSTICS

TEST DATE (MO/DAY/YR)	TYPE OF TEST	SPECIMEN TYPE	COLLECTION DATE (MO/DAY/YR)	QUALITATIVE / QUANTITATIVE RESULTS	REFERENCE RANGE	LABORATORY NAME/ADDRESS (INCLUDE STREET OR RFD, CITY, STATE, ZIP CODE)

42 - TREATMENTS

TREATED (Y/N/UNK)	REASON NOT TREATED	TYPE OF TREATMENT	DRUG	DOSAGE	TREATMENT DATE (MO/DAY/YR)	TREATMENT DURATION (IN DAYS)	PREVIOUS TREATMENT	PREVIOUS LOCATION (LIST CITY, STATE)

43 - SYMPTOMS

SYMPTOM (IF APPLICABLE)	SYMPTOM SITE (IF APPLICABLE)	SYMPTOM ONSET DATE (MO/DAY/YR)	SYMPTOM DURATION (IN DAYS)

44 COMMENTS

NOTES FOR ALL RELEVANT SECTIONS:

- Stages, risk factors, diagnostics, treatments, and symptoms shown below are examples. To see a more complete listing, please go to ***http://www.dhss.state.mo.us/Diseases/DDwelcome.htm***. You may also contact the Office of Surveillance at 1-800-392-0272 for additional information or to report a case.
- All dates should be in Mo/Day/Year (01/01/2001) format.
- All complete addresses should include city, state and zip code.
- Required fields referenced below are italicized and bold, however fill form as complete as possible.

(1) Date of Report -- date sent by submitter of document.

(2) Date received will be filled in by receiving agency.

(3-8) **CASE DEMOGRAPHICS/IDENTIFIERS:** ***Last name, First Name,*** Gender, ***Date of Birth,*** Hispanic, Race - please check all that apply

(23) Was patient hospitalized due to this illness?

(32) Type of reporter/submitter (doctor, nursing home, hospital, laboratory) (33-34) Attending physician or clinic (full physician name and degree, address, phone)

DISEASE: ***(35) Disease name or name(s), (36) Onset date(s), (37) Diagnosis Date(s)***

(38) Disease Stage or Risk Factor

Syphilis	**Gonorrhea or Chlamydia**	**TB Infection**
Primary (chancre present)	Asymptomatic	Contact to TB case
Secondary (skin lesions, rash)	Uncomplicated urogenital (urethritis, cervicitis)	Immunocompromised
Early Latent (asymptomatic < 1 year)	Salpingitis (PID)	Abnormal CXR
Late Latent (over 1 year duration)	Ophthalmia/conjunctivitis	Foreigner/Immigrant
Neurosyphilis	Other (arthritis, skin lesions, etc)	IV Drug/Alcohol Abuse
Cardiovascular		Resident, correctional
Congenital		Employee, correctional
Other		Over 70
		Homeless
		Diabetes
		Healthcare worker
		Converter/2 yrs ≥ 10
		Converter/2 yrs ≥ 15

(39) Previous Disease/Stage (if applicable) ***(40) Previous Disease Dates (if applicable)***

(41) Diagnostics (Please Attach Lab Slip)

Test Type

Hepatitis	**TB**	**Other**
Igm Anti-HBc	Not Done	Elisa
Anti-HBs	Mantoux	Western Blot
Anti-HBc Total	Multiple puncture device	Culture
Igm Anti-HAV	X-Ray	ALT
HBsAg	Smear	AST
Hep C	Culture	

Specimen Type (blood, urine, CSF, smear, swab), **Collection Date** (Mo/Day/Yr), **Qualitative** (negative, positive, reactive), **Quantitative Results** (1:1, 2.0 mm reading,) **Reference Range** (1:1neg, 1:64 equivocal, 1:128 positive, > 2 positive), **Laboratory** (name, address)

(42) TREATMENT

Reason not treated	**Drug**
False positive	**TB**
Previous treated	Isoniazid
Age	Ethambutol
	Pyrazinamide
	Rifampin

(43) SYMPTOMS:

Symptom (jaundice, fever, dark urine, headache) **Symptom Site** (head, liver, lungs, skin), **Symptom Onset Date** (Mo/Day/Yr) and **Symptom Duration** (in days)

(44) **Comments:** Attach additional sheets if more comments needed.

Missouri Department of Health and Senior services

Tuberculosis Drug Monitoring

Patient Name			Local Public Health Agency
Date of Birth	Age	Med Start Date:	☐ Suspect ☐ TB Case ☐ MOTT
		Med Stop Date:	☐ Completed Treatment ☐ Moved ☐ Died ☐ Not TB ☐ Lost

Use new form when medications are changed

Date of Visit										
Date of Next Visit										
INH _____mg ☐ Daily ☐ 2x Week ☐ 3 x Week										
Rifampin_____mg ☐ Daily ☐ 2x Week ☐ 3 x Week										
Ethambutol_____mg ☐ Daily ☐ 2x Week ☐ 3 x Week										
PZA _____mg ☐ Daily ☐ 2x Week ☐ 3 x Week										
Vitamin B6_____mg ☐ Daily ☐ 2x Week ☐ 3 x Week										
Other _____mg ☐ Daily ☐ 2x Week ☐ 3 x Week										
Medication DOT: Y or N										
DOT Given By: _____ **Self Administered Meds: Y or N**	Baseline									
Sputum Collected: Y or N (date)										
Patients Weight:										
LFT Collected: Y or N (date)										
Chest X-ray Done: Y or N (date)										
Adverse Effects All Drugs	Fatigue, Weakness*									
	Fever*, Chills*									
	Loss of Appetite*									
	Nausea, Vomiting*									
	Jaundice									
	Dark Brown Urine									
	Rash, Itching*									
	Joint Pain									
INH	Peripheral Neuritis									
Ethambutol	Blurred Vision: Y or N									
	Decreased Red/Green Vision Y or N									
	Screen Vision: LT									
	RT									
Rifampin	Birth Control Pills Taken?									
Any Drug	Other Symptoms									
Nurses Signature										

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR COMMUNICABLE DISEASE PREVENTION

REFUSAL OF PREVENTIVE THERAPY

FORM TO DOCUMENT REFUSAL OF ISONIAZID PREVENTIVE TREATMENT OF TUBERCULOSIS

You have been identified as being infected with tuberculosis. As explained to you earlier, you have a lifetime risk of developing tuberculosis disease. Your physician has prescribed a course of preventive treatment with isoniazid (INH). Treatment with this drug will prevent the disease in most individuals who complete a recommended course of this drug. The medication and the appropriate nursing supervision would be provided to you at no cost.

Without INH preventive treatment, the risk of developing tuberculosis in the first year following infection is approximately five percent, i.e. if the drug is not taken, the individual has one chance in twenty of developing active disease within that first year. After that first year, the risk of developing disease is less, but still significant. For recently infected individuals and others at high risk for disease, that risk is greater than any risk associated with the isoniazid preventive treatment.

I have read the information on this form about preventive therapy. I believe I understand the benefits and risks of taking preventive therapy. I have had an opportunity to ask questions which were answered to my satisfaction.

The Health Department has offered to provide me with the medication and the nursing supervision in order to decrease my risk for developing tuberculosis disease. However, I have chosen not to take the medication as recommended. If I should have a change of mind in my intention to take the medication, I understand that the Health Department will be available to advise me on this matter.

NAME (PRINT)	BIRTH DATE
ADDRESS (STREET, CITY, STATE, ZIP)	COUNTY
SIGNATURE OF PERSON REFUSING INH OR PARENT, GUARDIAN OR OTHER AUTHORIZED PERSON ▶	DATE
WITNESS NAME (PRINT)	
WITNESS SIGNATURE ▶	DATE

Missouri Department of Health and Senior Services

TUBERCULOSIS TESTING RECORD

A. PATIENT INFORMATION

Name (Last, First, Middle Initial)

Inmate Number	Student Id Number	Social Security Number

Address/Street	City	Zip code

County	Date of Birth	Sex
		☐ Male ☐ Female

Race:
☐ White ☐Asian or Pacific Islander
☐ Black ☐Am. Indian or Alaskan Native

Ethnic Origin:
☐Hispanic
☐Non-Hispanic

Occupation	Alien Number

Place of Employment	DCN Number

B. HISTORY OF TUBERCULIN TEST

Have you ever had a **BCG Vaccine**?
☐No ☐Yes ☐Unknown

Have you ever had a Tuberculin test ☐No ☐Yes ☐Unknown	When/Date
Results in **mm** of previous skin test	Type of test

C. CURRENT TUBERCULIN PPD MANTOUX TEST(S) /X-RAYS

Date administered	Date Read	Results in mm
Date administered	Date Read	Results in mm

Chest X-Ray Done ☐No ☐Yes	Date Done	Results: ☐Normal ☐Abnormal Findings:

D. HEALTH CARE PROVIDER

Name/Facility

Address	Phone Number

REPORTED BY

Name

Facility	Phone Number

Address

E. Reason for Testing

☐Contact to TB Case ☐Employment ☐Medically Referred ☐Symptomatic
Case Name_____
☐Immigration ☐Insurance ☐Educational enrollment ☐Resident ☐Other

Employer/Residence:
☐Long Term Care Facility ☐Department of Corrections ☐Health Care Facility
☐Substance Abuse Center ☐School/Day Care ☐County Jail ☐Other

I consent to a tuberculin skin test for the above reasons(s). I understand I am to have the skin test read in 48-72 hours by the designated reader/interpreter.

Client's/Guardian Signature **Date**

F. Risk Factors

Please Check all that apply:

☐Contact to TB Case – Close Case Name_____	☐Contact to TB Case Casual Case Name_____	☐Immunosuppressed
☐Abnormal Chest X-ray	☐I.V. Drug User	☐Foreign Born where TB is Common
☐Alcoholic	☐Homeless	☐Employee of Dept of Corrections
☐Younger than 4 years of age	☐Migrant Worker	☐Employee of Other Correctional Facility
☐Underserved/Low income	☐Diabetes Mellitus	☐Employee of Long Term Care Facility
☐Post-gastrectomy	☐Silicosis	☐Employee of Mental Health Facility
☐Prolonged corticosteriod therapy	☐Provides health care services	☐Resident of Dept of Corrections
☐10%or more below ideal body weight	☐Teaches high risk groups	☐Resident of Other Correctional Facility
☐Skin test converter with 2 years	☐No known risk factors	☐Resident of Long Term Care Facility
		☐Resident of Mental Health Facility

G. Treatment/Recommendations

Status: ☐ Closed ☐ Open	Latent TB Infection (LTBI): ☐ No ☐ Yes	Medication Provided by: ☐ Private Provider ☐ Health Dept

H. Medication

Drug/mg		Reason Treatment not Started
☐ INH_____ ☐B-6_____ ☐Rifampin_____ ☐PZA_____ ☐Other_____		☐Patient Refuses Therapy ☐Physician did not order ☐Medical Contraindication
Frequency	☐ Daily ☐ 2 or 3 times weekly	
Duration	(In Months)	
Start Date		

Comments:

PREVENTIVE TREATMENT MONITORING **CONTINUATION**

Patients Name				**Date of Birth**			Note: **9** months preventive treatment is recommended for all infected persons including children, except HIV positive individuals (12 months).						
Encounter Date:													
Allergies: ☐ No ☐ Yes ☐ NKA	**List:**												
Medications	**mg**												
B-6													
INH													
Rifampin													
PZA													
Other													
Adverse Effects		**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**	**Adverse Effects**
Fatigue, weakness													
Fever, chills													
Loss of Appetite													
Nausea													
Vomiting													
Jaundice													
Dark Brown Urine													
Rash													
Itching													
Joint Pain													
Other													
Other Medications:													
Liver Enzyme Collection Data		**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**	**LFTs (Y/N)**
ALT Results		ALT:	ALT:	ALT:	ALT:	ALT:	ALT:	ALT:	ALT:	ALT:	ALT:	ALT:	ALT:
AST Results		AST:	AST:	AST:	AST:	AST:	AST:	AST:	AST:	AST:	AST:	AST:	AST:
Next Encounter Date:													
Comments:													
Evaluator Name/Signature													

COMPLETION OF TREATMENT

Treatment stopped *(Month/Day/Year)*

Treatment Completed *(Month/Day/Year)*

Reason Treatment Stopped:

☐Completed Treatment
☐Death
☐Client Moved (Follow-up Unknown)
☐Client Chose to Stop
☐ Client is Lost to Follow-Up
☐ Provider Decision to Stop
☐ Physician Declined Preventive Therapy
☐ Active TB Developed
☐ Adverse Effect of Medicine
☐ No Therapy Needed
☐ Patient Refuses Preventive Therapy

Date:

Health Care Provider Signature:

Missouri Department of Health and Senior Services
PO Box 570
Jefferson City, Missouri 65102

TUBERCULOSIS HISTORY

Patient's Name _____ Age ____ Date of Birth____/____/____ Sex M F

To be completed by the Local Health Department Nurse.

TB History completed by:_____ Date: ____/____/____ County:_____

TB Treatment: ☐ Pulmonary ☐ Extrapulmonary _____ (site)

Bacteriology: Smear_____ Culture _____ NAA_____ **CXR:** ____ Normal ___Abnormal ___ Cavitary ___ Noncavitary ____ Not done

Initial drug regimen started:_____/_____/_____ ___INH (dosage)_____ ____ Rifampin (dosage)_____

____ PZA (dosage)_____ ____ Ethambutol (dosage)_____ ___ Other_____

Frequency: ____ Daily ____Twice weekly ____ Thrice weekly

Treatment Plan:_____ months. _____ Ethambutol discontinued _____/_____/_____ PZA discontinued _____/_____/_____

_____ INH discontinued _____/_____/_____

Continuation Phase Drug Regimen:

____INH (dosage)_____ ____ Rifampin (dosage)_____ ____Other_____

Frequency: ____ Daily ____Twice weekly ____Thrice weekly

List additional medications patient currently taking taking:_____

Reported Allergies:

Medical risk/social factors: Circle the appropriate answer to all questions

Y/N/U Contact to case _____	Y/N/U Abnormal CXR/old TB	Y/N/U Prior TB- inadequate treatment
Y/N/U PPD Convertor	Y/N/U Foreign born in US < 5 years	Y/N/U Excessive alcohol usage
Y/N/U Injectable drug use (within last year)	Y/N/U Non-injectable drug use (within last year)	Y/N/U Incarceration at time of diag
Y/N/U Homeless (within past year)	Y/N/U High risk employment_____	Y/N/U Resident/long term care
Y/N/U < 10% below ideal body weight	Y/N/U Diabetes	Y/N/U Cancer
Y/N/U HIV/AIDS	Y/N/U Rheumatoid arthritis	Y/N/U Crohn's disease
Y/N/U Was HIV/AIDS testing offered	Y/N/U Dialysis/Renal failure	Y/N/U Gastrectomy/intestinal bypass
Y/N/U Steriod therapy	Y/N/U Silicosis	Y/N/U Unable to read/understand directions
Y/N/U Organ transplant	Y/N/U Mental illness	Y/N/U Other_____

Date of onset of cough: _____/_____/_____ ___ Hemoptysis ____/____/____ Night sweats ____/____/____ ___Fever ____/____/____

____ Weight loss ____/____/____ ___Chest pain ____/____/____ ___Enlarged lymph nodes ____/____/____ ___ Other ____/____/____

Date of diagnosis: _____/_____/_____ Delays in diagnosis:_____

PPD done at diagnosis ____ Yes ____No Results _____ MM Date: _____/_____/_____

Previous PPD: ____ Yes ____No Results _____ MM Date: _____/_____/_____

LTBI Treatment received ____ Yes ____No Date: _____/_____/_____ Medications_____

To be completed by State Date reported to DHSS ____/____/____ By whom: LPHA, Hospital, Physician, other_____

Genotyping Results: Spoligo_____ MIRU_____ RFLP_____

Matches ____No _____ Yes RVCT# _____ RVCT#_____ RVCT#_____

<u>Missed opportunity for preventing TB</u>

____ Preventable: TB Risk factor, no PPD

____ Preventable: LTBI, No treatment (Excluding documented refusal)

____ Preventable: LTBI, incomplete treatment

____ Preventable: Contact to case, not identified prior to diagnosis of TB

____ Preventable: Secondary case to preventable case

____Not Preventable: Appropriate testing &/or treatment prior to diagnosis of TB

____Not Preventable: Foreign born, TB identified on entry into US

____Not Preventable: Recent entry to US, no exam abroad or in US prior to diagnosis of TB

<u>Missed opportunity for preventing TB death</u>

Was TB cause of death: ____ Yes ____No

Was TB a contributing factor to death: ____ Yes ____No

Was TB treatment cause of death: ____ Yes ____No

Was TB treatment a contributing factor: ____ Yes ____No

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

TUBERCULOSIS WORKSHEET FOR CONTACTS OF NEWLY DIAGNOSED CASES OF TB

TB INDEX CASE	DATE	COUNTY

NAME	ADDRESS	AGE	DATE OF BIRTH

TB INDEX CASE CHARACTERISTICS

1. AT TIME OF DIAGNOSIS WAS INDEX CASE COUGHING?	2. POSITIVE ON AFB SMEAR?	3. POSITIVE ON CULTURE?	4. IS INDEX CASE CLINICAL?	5. IS INDEX CASE PHYSICIAN DIAGNOSED?
☐ YES HOW LONG? _____ ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

NAME OF CONTACT IDENTIFIED	AGE OR DATE OF BIRTH	SEX	RACE	CLOSE CONTACT		MANTOUX TUBERCILIN TEST				X-RAY			STARTED PREVENTIVE TREATMENT			INFECTED WITH TB DISEASE		HISTORY					
						DATE OF INITIAL TEST	mm	DATE OF 3-MONTH FOLLOW-UP TEST	mm	DATE	RESULTS							PREVIOUS SKIN TEST		PREVIOUS X-RAY		PREVIOUS PREVENTIVE TREATMENT	
				YES	NO						NORMAL	ABNORMAL	YES	NO	DATE START	YES	NO	PRIOR TEST DATE	mm	DATE	RESULT	START DATE	END DATE
1. NAME																							
ADDRESS																							
2. NAME																							
ADDRESS																							
3. NAME																							
ADDRESS																							
4. NAME																							
ADDRESS																							
5. NAME																							
ADDRESS																							
6. NAME																							
ADDRESS																							
7. NAME																							
ADDRESS																							
8. NAME																							
ADDRESS																							

NAME OF CONTACT IDENTIFIED	AGE OR DATE OF BIRTH	SEX	RACE	CLOSE CONTACT		MANTOUX TUBERCILIN TEST				X-RAY			STARTED PREVENTIVE TREATMENT			INFECTED WITH TB DISEASE		HISTORY						
						DATE OF INITIAL TEST	mm	DATE OF 3-MONTH FOLLOW-UP TEST	mm	DATE	RESULTS							PREVIOUS SKIN TEST		PREVIOUS X-RAY		PREVIOUS PREVENTIVE TREATMENT	
				YES	NO						NORMAL	ABNORMAL	YES	NO	DATE START	YES	NO	PRIOR TEST DATE	mm	DATE	RESULT	START DATE	END DATE
9. NAME																							
ADDRESS																							
10. NAME																							
ADDRESS																							
11. NAME																							
ADDRESS																							
12. NAME																							
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13. NAME																							
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14. NAME																							
ADDRESS																							
15. NAME																							
ADDRESS																							
16. NAME																							
ADDRESS																							
17. NAME																							
ADDRESS																							
18. NAME																							
ADDRESS																							

SMEARS			CULTURES			X-RAYS			MEDICATION AND DOSAGE								
DATE	RESULT	LAB	DATE	RESULT	LAB	DATE	RESULT	WHERE?	DATE	INH	RIF	EMB	PZA	OTHER	COMPLIANCE	MED. EVAL.

HISTORY

SITE

☐ PULMONARY ☐ LYMPHATIC ☐ GENITOURINARY ☐ MILIARY ☐ BONE &/OR JOINT ☐ PLEURAL

☐ MENINGEAL ☐ PERITONEAL ☐ OTHER (SPECIFY) _____

SIGNIFICANT SITE(S) OTHER THAN PREDOMINANT SITE ▶

DATE OF DRUG RESISTANT CULTURE ▶

RESISTANT TO WHAT DRUGS?

NAME (LAST, FIRST)			
☐ REPORTED AT TIME OF DEATH ☐ PRIMARY ☐ SECONDARY	DATE OF DEATH		
INSTITUTION ☐ PENAL ☐ NURSING HOME ☐ MENTAL		INSTITUTION NAME	INSTITUTION ADDRESS
INSTITUTIONALIZED PRIOR TO DIAGNOSIS? ☐ YES ☐ NO			
CASE NO.		DATE CASE ENTERED	COUNTY

CONTACT FOLLOW-UP	TOTAL	FOR ALL CASES UNDER AGE 15			PULMONARY & LARYNGEAL CASES AGE 15 AND OVER		
		AGE OF CONTACTS			AGE OF CONTACTS		
		< 15	15 - 35	35 +	< 15	15 - 35	35 +
A. CONTACTS IDENTIFIED							
B. CONTACTS EXAMINED							
1. NOT INFECTED							
a. STARTED PREVENTIVE THERAPY							
2. INFECTED, WITHOUT DISEASE							
a. STARTED PREVENTIVE THERAPY							
b. PREVIOUS PREVENTIVE THERAPY							
3. INFECTED WITH DISEASE (TB)							

ADDITIONAL COMMENTS ▶ _____

MEDICAL EVALUATION CODES

A. PRIVATE PHYSICIAN (NAME)	D. PENAL (NAME)
B. CHEST CLINIC (NAME)	E. OTHER (NAME)
C. MILITARY (NAME)	

HISTORY

SMEARS			CULTURES			X-RAYS			MEDICATION AND DOSAGE							
DATE	RESULT	LAB	DATE	RESULT	LAB	DATE	RESULT	WHERE?	DATE	INH	RIF	EMB	STREP	OTHER	COMPLIANCE	MED. EVAL.

COMPLIANCE CODES ▶ **1.** TAKING ALL MEDS. **2.** OCCASIONALLY MISSES DOSES **3.** FREQUENTLY MISSES DOSES **4.** TAKES ERRATICALLY **5.** PROBABLY NOT TAKING MEDS. **6.** NOT TAKING MEDICATION

IDENTIFICATION INFORMATION AND PERSONAL HISTORY

AGE	SEX	☐ 1. WHITE **RACE** ☐ HISPANIC	REPORTED BY (NAME OF PHYSICIAN, HOSPITAL, ETC.)	
		☐ 2. BLACK ☐ NON-HISPANIC		
DOB		☐ 3. ASIAN OR PACIFIC ISLANDER	ADDRESS	PHONE NO.
		☐ 4. AMERICAN INDIAN OR ALASKAN NATIVE		

PATIENT'S ADDRESS

1.	DATE
2.	DATE
3.	DATE
4.	DATE

TUBERCULIN SKIN TEST AT TIME OF DIAGNOSIS:

MANTOUX: ☐ SIGNIFICANT _____ mm

☐ NON SIGNIFICANT _____ mm

OTHER TEST TYPE ▶ _____

RESULT ▶

PREVIOUS SKIN TEST	
TYPE	RESULT
DATE	

PREVIOUS DISEASE? ☐ YES ☐ NO

WHERE REPORTED? _____

IF YES, INDICATE YEAR OF PREVIOUS DIAGNOSIS

▶ _____.

IF MORE THAN ONE PREVIOUS EPISODE CHECK HERE ▶ ☐

HOSPITALIZATION

HOSPITAL AND ADDRESS	ADMISSION	DISCHARGE	HOSPITAL NO.
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

TUBERCULOSIS MEDICATION RECORD

NAME	START DATE / /	CURRENT MONTH	ALLERGIES

MEDS/DOSE/FREQ	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
INH																															
RIF																															
PZA																															
EMB																															

INH = Isoniazid RIF = Rifampin PZA = Pyrazinamide EMB = Ethambutol B6 = Pyridoxine

Codes: D = DOT S = Self Administered F = Failed Dose (In Red) H = Held Dose DC = Discontinued X = Special Circumstance

(If given by the DOT the Health Care worker and Patient should initial form each day medication is given/ingested)

CW SIGNATURE	INITIALS	PATIENT SIGNATURE	INITIALS

COMPLETED DOSES TAKEN THIS MONTH	COMPLETED DOSES TAKEN TO DATE
_____ daily _____ 2x/wk _____ 3x/wk	_____ daily _____ 2x/wk _____ 3x/wk

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

TUBERCULIN SKIN TEST RECORD

NAME
DATE OF BIRTH
ADDRESS
CITY, STATE, ZIP CODE
SEE BACK OF CARD FOR SKIN TEST RESULTS

MO 580-0840 (6-02) TBC-18

DATE		TEST TYPE	PROVIDER & AGENCY SIGNATURE	RESULTS
GIVEN MO/DAY/YR	READ MO/DAY/YR			
				mm
				mm
				mm
				mm
				mm
				mm
				mm
COMMENTS				
RETAIN THIS DOCUMENT AS PROOF OF TUBERCULIN SKIN TESTING				

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER
services provided on a nondiscriminatory basis

Missouri Deaprtment of Health & Senior Services

Certificate of Completion for TB Treatment

_____

has successfully completed _____ months
of treatment for Tuberculosis/LTBI

For more information, contact:
_____ County Health Department

Telephone: ( ) _____

MO 580-2689 (12-03) TBC-19

Meds:	Dosage	Date Started	Date Completed
INH			
RIF			
PZA			
EMB			
SM			
Last negative culture:			Date:
Last CXR results:			Date:
PPD results:		mm	Date:

MO 580-2689 (12-03) TBC-19

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR COMMUNICABLE DISEASE PREVENTION

DIAGNOSTIC SERVICES ELIGIBILITY/AUTHORIZATION (TB)

PATIENT'S NAME			SEX ☐ MALE ☐ FEMALE
ADDRESS	CITY	COUNTY	ZIP CODE
TELEPHONE ( )	SOCIAL SECURITY NUMBER	BIRTHDATE (MONTH/DAY/YEAR)	
1. IS PATIENT COVERED BY MEDICAID OR MEDICARE? ☐ YES ☐ NO	2. IS PATIENT COVERED BY ANY OTHER HEALTH INSURANCE? ☐ YES ☐ NO	3. IS PATIENT COVERED BY VA BENEFITS? ☐ YES ☐ NO	

I affirm by my signature (mark) that the above statements are true to the best of my knowledge. I understand Diagnostic Services are for evaluation of TB infection/disease (initial office visit, chest x-ray) with subsequent follow-up visits if necessary and approved through the _____ County/City Health Department by the Disease Investigation Unit. **Diagnostic Services will only pay for office visits, chest x-ray and sputum induction (if needed). Any other services obtained are not covered and are the responsibility of client (e.g. CT scans and routine labs).**

I also give my permission to the _____ County/City Health Department to share needed information with the provider to obtain these services and also authorize the care provider to share information with the county/city health department.

SIGNATURE OF CLIENT OR PARENT/GUARDIAN (IF CLIENT IS A MINOR)	DATE

DATE PPD TEST GIVEN	DATE READ	RESULTS	RISK FACTORS

PHYSICIAN PROVIDER			
PHYSICIAN ADDRESS	CITY	COUNTY	TELEPHONE
HEALTH DEPARTMENT EMPLOYEE SIGNATURE/HEALTH DEPARTMENT			DATE

DHSS USE ONLY

PRE-AUTHORIZATION NUMBER	DATE AUTHORIZED	AUTHORIZED BY

TYPE OF SERVICE NEEDED	UNITS AUTHORIZED
☐ FIRST OFFICE VISIT (99205)	
☐ SUBSEQUENT OFFICE VISITS (99215)	
☐ CHEST X-RAY (71020)	
☐ CHEST X-RAY INTERPRETATION (71020A)	
☐ INDUCED SPUTUM COLLECTION (89350)	
☐ OTHER	

ANNUAL STATEMENT FOR TUBERCULIN REACTORS

NAME: _____

DATE OF BIRTH: _____

SIGNS/SYMPTOMS SCREENING (Yes/No):

_____ Cough lasting longer than three (3) weeks
_____ Unexplained fever
_____ Night sweats
_____ Unexplained weight loss
_____ Coughing up blood
_____ Chest pain

IF NONE OF THESE SYMPTOMS ARE PRESENT, A CHEST X-RAY IS NOT NECESSARY.

_____ _____
Nurse/Physician Date

[ ] I am tuberculin positive. I have had the recommended course of treatment for **tuberculosis infection** (LTBI).

[ ] I am tuberculin positive. I have had the recommended course of treatment for **tuberculosis disease**.

[ ] I am tuberculin positive. I have had one negative chest x-ray since becoming tuberculin skin test positive.

If I develop any of the above symptoms, I agree to seek immediate medical attention.

_____ _____
Patient Date

Check list for Active Disease Case

INITIAL WORKUP:

	YES	NO	NA	Notes
CD-1 completed				
Conduct patient interview				
Complete TB History (TBC-10) Form				
CD-1&TB History Form faxed/ mailed to state TB nurse				
Release of information signed				
Contact/source case investigation initiated				
Patient education provided in client's primary language and documented, Isolation procedures as needed				
Admission note completed				
Sputums sent to MRC for culture & sensitivity				
Diagnostic services arranged, if needed				
HIV testing offered				
Baseline LFT and eye exam, if applicable				
Prescriptions obtained and faxed to state contract pharmacy				
DOT initiated				
Contact form mailed to district office (TBC-13)				

DURING TREATMENT:

	MONTH 1	MONTH 2	MONTH 3	MONTH 4	MONTH 5	MONTH 6
Assess & document on TBC-1						
LFT, if indicated						
DOT (# of doses this month)						
Sputums submitted						
TBC-1 sent to state TB nurse						

COMPLETION OF TREATMENT:

	YES	NO	Notes
Completion of therapy documented (including # of doses received)			
Completion letter to client			
State TB Nurse notified			

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF COMMUNITY AND PUBLIC HEALTH

COHORT PRESENTATION: TB CASES
PULMONARY/EXTRAPULMONARY TB CASE

1. NAME	DATE RVCT SUBMITTED TO TB PROGRAM (J.C.) / /	RVCT #	COUNTY

AGE	SEX	RACE	BORN IN (COUNTRY)	ARRIVED IN THE US	CLASS
	☐ M ☐ F			/ /	☐ A ☐ B1 ☐ B2

IS CASE EMPLOYED?	TYPE OF WORK
☐ YES ☐ NO	

RISK/SOCIAL FACTORS

☐ NONE ☐ MEDICAL CONDITIONS ☐ SUBSTANCE ABUSE ☐ HOMELESS ☐ EMPLOYMENT ☐ OTHER, SPECIFY:

HIV STATUS	HIV TEST DATE	HIV MEDS	PI/NNRTI (NAME)
☐ POSITIVE ☐ NEGATIVE ☐ REFUSED ☐ NOT DONE	/ /	☐ YES ☐ NO	

FOR EACH CASE COMPLETE 2a, OR 2b, OR 2c

2a. PULMONARY SPUTUM SMEAR POSITIVE	2b. SPUTUM SMEAR NEGATIVE SPUTUM CULTURE POSITIVE	2c. OTHER: (PEDIATRIC, BIOPSY, BRONCHSCOPY, OTHER CULTURE POSITIVE, CLINICAL OR DOCTOR DIAGNOSED CASES)
a) ☐ Pulmonary TB	a) ☐ Pulmonary TB	a) ☐ Pulmonary TB
☐ (Both) Pulmonary & Extrapulmonary	☐ (Both) Pulmonary & Extrapulmonary	☐ Extrapulmonary _____ (site)
_____ (site)	_____ (site)	b) Sputum status: ☐ negative ☐ not done
b) Sputum collection date: ____ / ____ / ____	**b) Sputum smear negative.**	☐ smear positive/culture negative
Sputum smear (+) _____ plus.	**c) Sputum smear positive.**	c) Microscopic exam of tissues or other body fluids
Sputum report date: ____ / ____ / ____	Collection date: ____ / ____ / ____	Source of specimen _____
c) Culture: ☐ positive ☐ negative ☐ not done	d) Culture source: _____	Results: ☐ positive ☐ negative ☐ not done
Report date: ____ / ____ / ____	e) Date LPHA notified: ____ / ____ / ____	d) If not laboratory confirmed, is case a
d) If culture positive, Source: _____	f) Date interviewed: ____ / ____ / ____	☐ Clinical case ☐ Doctor's diagnosis
e) Date LPHA notified: ____ / ____ / ____	If > 3 working days for interview - state reason:	e) Date LPHA notified: ____ / ____ / ____
f) Date interviewed: ____ / ____ / ____	_____	f) Date interviewed: ____ / ____ / ____
If > 3 working days for interview - state reason:	g) After 2 months of therapy, has sp. culture conversion to (+) occurred? ☐ Yes ☐ No	If > 3 days for interview - state reason:
_____	FC Date: ____ / ____ / ____	_____
g) Has 3 consecutive (-) AFB sputum smears on 3 different days collected? ☐ Yes ☐ No	Comments:	
FS Date: ____ / ____ / ____		
h) After 2 months of therapy, has sp. culture conversion to (+) occurred? ☐ Yes ☐ No		
FC Date: ____ / ____ / ____		

DRUG SUSCEPTIBILITY RESULTS

☐ PANSENSITIVE ☐ RIFAMPIN RESISTANT ☐ INH RESISTANT ☐ MDR (INH & RIFAMPIN) ☐ OTHER RESISTANCE, SPECIFY:

CHEST X-RAY DATE	RESULTS
/ /	☐ NORMAL ☐ ABNORMAL CAVITARY ☐ ABNORMAL NONCAVITARY ☐ NOT DONE

3a. TREATMENT OUTCOME AT TIME OF COHORT

FOUR-DRUG REGIMEN	IF NO, REASON	STARTED ON	TREATMENT PLAN OF
☐ YES ☐ NO		/ /	WEEKS

☐ **COMPLETED THERAPY** _____ NUMBER DOSES TAKEN ☐ **TAKING TB MEDICATIONS** HAS COMPLETED _____ WEEKS OF TX. _____ NUMBER OF DOSES

☐ **DID NOT COMPLETE TREATMENT (REASON):** ☐ REFUSED ☐ LOST ☐ DIED ☐ REPORTED AT DEATH ☐ ADVERSE REACTION ☐ PROVIDER DECISION

☐ MOVED WHERE: _____ DATE OF JURISDICTIONAL REFERRAL: ____ /____ / ____ _____ NUMBER OF DOSES TAKEN

3b. ON DOT	NO. OF WEEKS ON DOT	NUMBER DOSES TAKEN ON DOT	IF NO DOT, WHY
☐ YES ☐ NO			

4. A CASE ≤18 YEARS OF AGE SHOULD HAVE A SOURCE CASE INVESTIGATION.	**SOURCE CASE IDENTIFIED?** ☐ YES ☐ NO ☐ N/A	IF NO, WHY?

TB cases with extrapulmonary disease only do not require contact investigations.

Is an expanded contact investigation associated with this case? ☐ Yes ☐ No If yes explain: _____

5. Contacts

_____ **Number of contacts identified** (includes all those with potential exposure)

_____ **Number of contacts appropriate for evaluation** (AE) - (close contacts only, exclude those with minimal or no contact or died before testing completed).

_____ **Number** of (AE) **contacts evaluated** (TST and/or symptom review & CXR - for TST include **only** those with 3 month testing)

_____ Number with prior TB disease → _____ Number evaluated (symptom review & chest x-ray)

_____ Number with prior positive TST → _____ Number evaluated (symptom review & chest x-ray)

_____ Number of (AE) contacts with new positive TST → _____ Number evaluated (symptom review & chest x-ray)

_____ Number of (AE) contacts with negative TST _____ Number of (AE) contacts with **no disease** (confirmed by chest x-ray)

_____ Number started on LTBI _____ Number of contacts appropriate for LTBI treatment

_____ Number completed treatment for LTBI

_____ Number expected to complete LTBI treatment

_____ Number discontinued treatment for LTBI Reason: ☐ Death ☐ Contact moved (follow-up unknown)

☐ Adverse Effect of Medicine ☐ Contact chose to stop ☐ Lost to follow-up ☐ Provider Decision

☐ Developed TB Disease ☐ Other, specify: _____

_____ Number of TST positive contacts Lost to follow-up

_____ Number of (AE) contacts **Not Evaluated** (No TST or Testing incomplete or No symptom review & Chest x-ray)

Reason: _____

_____ Number of (AE) contacts with TB Disease → _____ Number started on Treatment

_____ Number not Treated, Reason: _____

_____ **Number of new TB disease cases Lost to follow-up**

Items Needing Follow-Up/Discussion points: _____

_____

_____

For prior TST positive cases (with no hx LTBI trt.) & new TST positive cases that refused LTBI treatment; document in LTBI register; "**case refused LTBI treatment**"

(*5 mm TST cutoff for TB disease contacts)

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

PARTICIPATION AGREEMENT FOR PROFESSIONAL AND SPECIAL SERVICES PROVIDER

AGREEMENT NUMBER	O.A. VENDOR NUMBER

FUNDING SOURCE

FEDERAL AGENCY NAME	FEDERAL AWARD YEAR	STATE %	FEDERAL %
FEDERAL AWARD NUMBER		RESEARCH & DEVELOPMENT YES☐ NO ☐	SUBJECT TO A-133 REQUIREMENTS YES☐ NO ☐
FEDERAL AWARD NAME		CFDA NUMBER	CFDA TITLE

1. By signing below the Provider agrees to provide services or goods as needed to Missouri Department of Health and Senior Services (hereinafter referred to as Department) approved clients.
2. This agreement shall consist of this form, the attached Business Associate Provisions document, and the attached Terms and Conditions document which are incorporated herein by reference.
3. The Provider shall comply with the policies and procedures required by the Department in the delivery of services, supplies, appliances or pharmaceuticals and in submitting claims for payment, as described in the Program Billing Guidelines which are incorporated herein as if fully set out. The Department shall provide guidelines to the Provider.
4. Services authorized and resulting charges are subject to review and approval by the Department. Payments for service shall be in accordance with Program Billing guidelines in effect at the time services are provided.
5. The Provider shall make all reasonable efforts to pursue third-party payments for services subject to this agreement, unless otherwise indicated in Program Billing Guidelines. The Department must be notified within sixty (60) days of the Provider's receipt of third-party payment.
6. The Provider shall not require or request payment for authorized services from clients covered by this Agreement. The Provider shall have the express right to bill clients covered under this Agreement for services that are not authorized. Unauthorized services are those for which the Department has not given specific prior authorization. All billings for services provided to approved clients must be submitted to the Department no later than sixty (60) days following the date of services provided except that all bills must be submitted no later than thirty (30) days after the close of the state fiscal year on June 30, of each year.
7. Obligations under this agreement shall be suspended at such time as funds are not available to cover payment for services provided to qualified clients. However, suspension shall not eliminate coverage under this agreement for services which had been approved by the Department and which had already been furnished prior to the date of suspension.
8. This agreement shall be effective on the date of approval by the Department and shall continue in effect until such time as either party invokes termination as set forth in the attached Terms and Conditions document. Following any three- year period during which no services have been provided by the Provider in regard to this agreement, this agreement shall cease.
9. The Provider acknowledges that pursuant to the Federal Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164), it is a business associate of the Department and it shall comply with the additional Business Associate Provisions document attached hereto and incorporated herein by reference.
10. If the Provider has not already submitted a properly completed State Vendor ACH/EFT Application for deposit into a bank account of the Provider, such Application shall accompany the partially-executed Agreement at the time the Provider returns the Agreement to the Department, as the Department will make payments to the Provider through Electronic Funds Transfer. Payment may be delayed until the ACH/EFT application is completed and approved.

PROVIDER NAME (PLEASE TYPE)	PAYMENT MAILING ADDRESS (STREET, CITY, STATE, ZIP)
NAME OF AUTHORIZED REPRESENTATIVE	
SIGNATURE OF PROVIDER OR REPRESENTATIVE DATE ▶	E-MAIL ADDRESS

FEDERAL TAX I.D. OR SOCIAL SECURITY NO.	STATE LICENSE NO. (IF APPLICABLE)	TELEPHONE NUMBER

TYPE OF PROVIDER

☐ HOSPITAL ☐ PHARMACY ☐ DENTIST ☐ THERAPIST

☐ PHYSICIAN (M.D./D.O.) ☐ OTHER

CERTIFIED MINORITY OR WOMEN BUSINESS ENTERPRISE (MBE / WBE)

☐ YES ☐ NO

PROVIDER ENROLLMENT APPROVED

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES, DIVISION OF ADMINISTRATION DIRECTOR OR DESIGNEE ▶	TITLE **Director or Designee, Division of Administration**	DATE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

TB MEDICATION REQUEST

☐ NEW ☐ REFILL

FOR NEW ORDERS CALL 800-392-5586 OR FAX 660-584-5589
PLEASE MAIL OR FAX REFILL REQUESTS

HEALTH UNIT

CLIENT INFORMATION

NAME	DATE OF BIRTH	WEIGHT

ADDRESS (STREET, CITY, ZIP CODE)	SOCIAL SECURITY #

PRESCRIPTION INSURANCE INFORMATION (ATTACH COPY OF CARD AT BOTTOM OF PAGE IF AVAILABLE)

INSURANCE PLAN (ie: MEDICAID, BLUE CHOICE, PCS, UNITED HEALTHCARE)		CLIENT'S RELATIONSHIP TO CARDHOLDER (ie: SELF, SPOUSE, DEPENDENT)

CARDHOLDER ID #	GROUP #	CLIENT'S ID # (IF DIFFERENT THAN CARDHOLDER)

PHYSICIAN INFORMATION

NAME	TELEPHONE #

ADDRESS (STREET, CITY, STATE, ZIP CODE)

ADDITIONAL MEDICATIONS BEING TAKEN	DRUG ALLERGIES

TOTAL DURATION OF THERAPY _____ MONTHS

MEDICATION ORDER

ITEM	RX NUMBER	ITEM	RX NUMBER

PERSON COMPLETING FORM

NAME	TELEPHONE #

ATTACH COPIES OF PRESCRIPTION IF AVAILABLE

FAX FORM TO: 660-584-5589
OR MAIL TO: PREFERRED PHARMACY SERVICES
810 W. 35TH ST., STE 102
HIGGINSVILLE, MO 64037

PLEASE PLACE COPY OF INSURANCE CARD HERE

NURSING CARE PLAN

NAME:_____ DOB:_____

Date	NURSING DIAGNOSIS	INTERVENTION	OUTCOMES
	Altered health maintenance related to insufficient knowledge of disease process.	1. Assess patient's current understanding of active tuberculosis	Patient will verbalize understanding of education provided.
		2. Provide verbal education to patient and supply with written information regarding tuberculosis. Instruction should be at educational level appropriate for patient. Translation of information will be made available, if needed.	Patient will be compliant with treatment and specimen collection.
		3. Provide education regarding treatment of tuberculosis including basic medication information. Education will be made available in client's primary language.	Patient will verbalize understanding of TB treatment and medications.
		4. Provide instruction on sputum collection and rationale for collection.	
		5. Provide instructions and rationale for isolation precautions.	

Altered nutrition: less than body requirements related to anorexia secondary to disease process.	1. Assess dietary habits and needs.	Patient will verbalize understanding of education provided.
	2. Assess ability to obtain food and prepare meals.	Patient will have improved appetite.

NURSING DIAGNOSIS	INTERVENTION	OUTCOMES
	3. Provide basic nutritional education to patient.	Patient will have adequate nutritional intake.
	4. Encourage small meals and nutritional supplements if needed.	
Alteration in comfort related to nausea and/or vomiting.	1. Assess for signs of dehydration.	Patient will verbalize understanding of education provided.
	2. Assess onset, duration of nausea and/or vomiting.	Patient will have a decrease in symptoms.
	3. Encourage small, frequent meals.	
	4. Educate regarding antiemetics.	

Social isolation related to disease process (contagiousness).	1. Assess patient's emotional status and coping ability.	Patient will verbalize understanding of education provided.
	2. Encourage phone conversations or letter-writing to maintain contact with others.	Patient will verbalize decrease in feelings of loneliness and isolation.
	3. Instruct patient in proper use of mask.	
	4. Provide education to patient about criteria for release from isolation precautions.	

Clients Name _____

Medical Record # _____

ONGOING/DISCHARGE EVALUATION OF TEACHING

The Client with Pulmonary Tuberculosis

Teaching Tools:

Printed materials given:_____

Audiovisual aids used:_____

Return Information/Demonstration/Interpretation

_____ Client
_____ Caregiver

OF:	Met	Not Met	Comments
( ) Nature of disease process; current status of disease.	_____	_____	_____
( ) S&S of complications; actions to take.	_____	_____	_____
( ) Importance of compliance with prescribed long-term treatment regimen.	_____	_____	_____
( ) How to take temperature and read a thermometer.	_____	_____	_____
( ) Measures to relieve pleuritic pain,fatigue and muscle strain related to coughing.	_____	_____	_____

( ) Well-balanced diet high in carbohydrates and protein, increased fluids. _____ _____ _____

( ) Predisposing factors to decreased oral intake, measures to correct. _____ _____ _____

( ) Measures to treat fluid losses. _____ _____ _____

( ) Weigh weekly; record;report excessive weight loss to physician. _____ _____ _____

( ) Medications and administration, purpose and action, side effects, toxicity. _____ _____ _____

( ) Progressive functional activities within limits of condition, balanced rest periods. _____ _____ _____

( ) Measures of infection control. _____ _____ _____

( ) Understand need for and purpose of sputum specimens and other diagnostic work. _____ _____ _____

Signature of County Health Nurse_____ Date _____

Insert Your Letterhead Here **SAMPLE**

Patient Care Agreement
Hospital Quarantine Confinement Instructions

Name_____

Date of Quarantine Confinement_____

I, _____, patient/guardian, have received information explaining responsibilities for adhering to the rules of hospital quarantine confinement, which I accept as an effective part of my plan of treatment for tuberculosis.

I AGREE TO COMPLY WITH THE FOLLOWING INSTRUCTIONS:

1. Remain confined to my assigned room, unless escorted or instructed by hospital personnel to leave the room.
2. Wear a mask covering my nose and mouth when requested.
3. Take all medications, treatments and medical procedures for tuberculosis treatment prescribed by the physician.
4. Report to the hospital staff and/or physician any problem with medications and/or treatment procedures.
5. Will keep all follow-up appointments when the quarantine confinement and hospitalization has been rescinded.

I the undersigned understand and here by agree to follow the above instructions as explained to me. I understand that at anytime that I do not follow these instructions I may be committed by court order to the Missouri Rehabilitation Center, Mt Vernon, Missouri, for the duration of my treatment.

I certify that I have received a copy of the instructions.

_____ _____
Patient Signature Date

_____ _____
Witness Signature/Title Date

Tuberculosis Signs & Symptoms Checklist

Client Name:_____ Date:_____

1. Have you ever had a positive TB skin test?	Yes	No
If yes, have you received treatment?	Yes	No
When_____		
2. Do you smoke?	Yes	No
3. Do you have a cough?	Yes	No
4. Do you cough up anything?	Yes	No
5. Do you cough up blood?	Yes	No
6. Have you lost weight?	Yes	No
7. Has your appetite decreased?	Yes	No
8. Do you have fever or chills?	Yes	No
9. Do you have night sweats?	Yes	No
10. Do you feel unusually tired or weak?	Yes	No
11. Do you have chest pains?	Yes	No
12. Have you been in close contact with someone who has TB?	Yes	No
13. Have you taken prednisone or steroids recently?	Yes	No
14. Have you recently been treated for cancer?	Yes	No
15. Have you ever been diagnosed with hepatitis or liver disease?	Yes	No
16. Do you drink alcohol?	Yes	No

17. What is your current method of birth control?_____

18. Are you pregnant?_____ Date of LMP:_____

19. How long have you lived in the United States?_____

Comments:_____

_____

_____

HOJA DE ENTREVISTA DE TUBERCULOSIS

Nombre:_____ Fecha:_____

1. Usted ha tenido siempre una prueba positiva de la tuberculosis?	SI	NO
Si si, usted ha recibido el tratamiento?	SI	NO
Cuando? _____		
2. Usted fuma?	SI	NO
3. Tiene usted tos?	SI	NO
4. Usted tose cualquier cosa?	SI	NO
5. Usted tose sangre?	SI	NO
6. Ha perdido peso?	SI	NO
7. El appetite ha disminuido?	SI	NO
8. Tiene fibre o escalofrios?	SI	NO
9. Usted suda en la noche?	SI	NO
10. Tiene dolor en el pecho?	SI	NO
11. Usted se siente inusualmente cansado o debil?	SI	NO
12. Usted ha estado en contacto cercano con alguien que tien tuberculosis?	SI	NO
13. Usted ha tomado el prednisone o los esteroides recientemente?	SI	NO
14. Ha tenido algun tratmiento para el cancer recientemente?	SI	NO
15. Le siempre han diagnosticado con hepatitis o enfennedad del higado?	SI	NO
16. Usted bebe el alcohol?	SI	NO

17. Se usa anticonseptivos?
Cual tipo? Patillas _____ Inyeccion _____ Condoms _____

18. Esta embarazada? SI NO La fechna de la utima regla:_____

19. Cuanto tiempo lleva en los Estados Unidos?_____

COMENTARIOS:_____

_____